SCJ/NES:PEN/FTB
F. #2013R01395

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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UNITED STATES OF AMERICA

- against -

Docket No. 14–CR-277 (DLI)

SYED IMRAN AHMED,

Defendant.

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GOVERNMENT'S OPPOSITION TO THE DEFENDANT'S MOTIONS IN LIMINE

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TABLE OF CONTENTS

PRELIMINARY STATEMENT……………………………………………………………. 1

ARGUMENT

I. Evidence that Other Insurance Providers Were Defrauded Should Not Be Precluded……………………………………………………………….. 2

II. Evidence of $1 Million Wire Transfer Should Not Be Precluded ………….. 3

A. Relevant Facts ………………………………………………….... 3

B. Discussion ………………………………………………………. . 4

III. Evidence of Peer Comparison and Spike in Claims Should Not Be Precluded ……………………………………………………………… 5

A. Relevant Facts …………………………………………………….. 5

B. Discussion ………………………………………………………… 6

IV. Identification of Claims Related to Operating Room Logs and Impossible Days ……………………………………………………………. 9

CONCLUSION……………………………………………………………………. 10

PRELIMINARY STATEMENT

The government respectfully submits this motion in opposition to the defendant's motions in limine in advance of the upcoming trial in this matter, which is currently scheduled to begin on June 13, 2016. The defendant is a general surgeon, who is accused of submitting fraudulent claims for reimbursement to the Medicare program for surgical procedures that he was not in fact performing. The indictment in this case charges the defendant with one count of health care fraud in violation of 18 U.S.C. § 1347; three counts of making false statements related to health care matters in violation of 18 U.S.C. § 1035; and two counts of transactional money laundering in violation of 18 U.S.C. § 1957.

The defendant moves to preclude evidence of (1) billings to health insurance providers other than Medicare; (2) a $1 million wire transfer by the defendant's wife to Pakistan; and (3) peer comparison Medicare data and a spike in the volume of the defendant's Medicare claims. For the reasons set forth below, these motions are without merit and should be denied.

The defendant also moves for a Bill of Particulars to immediately disclose Medicare claims underlying the government's (1) comparison of hospital operating logs to Medicare billings and (2) analysis of Medicare billings that reflect "impossible days." While not appropriate for a Bill of Particulars, for the reasons set forth below, the government will comply with the defendant's request.

ARGUMENT

I. Evidence that Other Insurance Providers Were Defrauded Should Not Be Precluded

The defendant moves to preclude evidence that bills which the defendant submitted to Medicare were also, at times, submitted by Medicare beneficiaries to Medicaid or their private supplemental health insurance providers. (Def. Mot. at page 2)[1] These other insurance providers paid any balance that remained on the bills after Medicare paid the claims. The defendant claims that this evidence is irrelevant and, in the alternative, should be precluded under Fed. R. Evid. Rule 403.

For the reasons more fully set forth in the government's motion in limine filed February 5, 2016, this evidence should be admitted as it is inextricably intertwined with evidence of the charged Medicare fraud scheme and the testimony of Medicare beneficiaries concerning the means by which they came to realize that the defendant had billed for services that he did not perform. Alternatively, the evidence is admissible pursuant to Fed. Rule Evid. Rule 404(b) to show the defendant's intent, common scheme or plan and absence of mistake. The evidence should not be precluded under Fed. Rule Evid. Rule 403, as the incremental prejudice to the defendant from the jury's learning that other insurance providers also received false claims arising from the same scheme described in the indictment is outweighed by the probative value of the evidence's showing the repeated pattern of fraudulent billing.[2]

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[1] References to "Def. Mot." refer to the Defendant's Memorandum of Law in support of his motions in limine filed February 5, 2016. References to "p." refer to pages contained within that Memorandum of Law.

[2] In Def. Mot. footnote 2, the defendant states that, if the Court were to allow evidence of the submission of claims to the other insurers, it should be limited to cases related to the specific

II. Evidence of $1 Million Wire Transfer Should Not Be Precluded

The defendant moves to preclude the admission of evidence of a $1 million wire transfer made by the defendant's wife to an account held by the defendant in Pakistan. (Def. Mot. at p. 4) For the reasons set forth below, this motion should be denied.

A. Relevant Facts

Counts Five and Six of the Indictment each charge the defendant with a violation of 18 U.S.C. §1957 (unlawful monetary transactions). Count Five relates to a $1 million wire transfer that the defendant sent from domestic TD Bank account ending in 5668 to an account in his name at a bank in Pakistan ("the first money transfer"). Count Six relates to a $1,000,000 check, which was drawn by defendant from the same TD Bank account ending in 5668, which that was deposited in a different domestic TD bank account ending in 8506 ("the second money transfer"). TD Bank account ending in 5668 was the account to which Medicare deposited money in payment of the defendant's false Medicare claims. Unrelated to a count of the Indictment, the defendant's wife made a $1 million wire transfer from domestic Commerce Bank account ending in 4999, which was a joint bank account held with the defendant, to a bank account in the defendant's name in Pakistan ("the third money transfer"). These three transactions all occurred on September 9, 2013, which was within a few days from when law enforcement first questioned the defendant about his fraudulent scheme.

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beneficiaries identified by the government in its September 14, 2015 letter (as supplemented by its January 8, 2016 letter) (the "Notice Letters"). The government only plans to admit this evidence from a few selected beneficiaries that have previously been identified in the Notice Letters. The government notes that one such beneficiary had primary health insurance through the Medicaid program; no claims were submitted to Medicare for this beneficiary. The claims data for this patient (and for other Medicaid patients) was produced to the defense on February 25, 2015.

B. Discussion

In addition to proving the crimes charged, the government will argue that the first and second money transfers show the defendant's desire to prevent the government from recouping the proceeds of his fraudulent scheme. We will also argue that the first money transfer -- a wire transfer to Pakistan -- specifically shows his preparations to flee the country to avoid prosecution.

The defendant argues that evidence of the third money transfer "has little probative value." (Id.) To the contrary, evidence of this third money transfer, which was sent, albeit by his wife, to his benefit in Pakistan is further evidence of his attempt to send assets overseas so that he could support himself after he fled the United States. As such, this evidence is relevant to show the defendant's knowledge and consciousness of guilt. While the defendant argues that the evidence may "lure the factfinder into declaring guilt on a ground different from proof specific to the offense charged (Id.)," the jury will have little trouble differentiating the money transfers related to Counts Five and Six, which are specifically identified in the indictment, from third money transfer. Moreover, the Court can give a simple curative instruction to the jury noting that no crime was charged in relation to the third money transfer to avoid any potential confusion.

Finally, the defendant claims that the evidence of third money transfer will add to the prejudice inuring to the defendant by the identification of Pakistan as the destination of the wire transfer. (Id. at 4-5) As with the first money transfer, the government would agree to redact the mention of Pakistan from the evidence and only show, perhaps by a stipulation between the parties, that the wire transfer was to the defendant's country of birth from which extradition is difficult.

III. Evidence of Peer Comparison and Spike in Claims Should Not Be Precluded

The defendant moves to preclude the government from offering highly probative circumstantial evidence to show that his billings to Medicare were grossly disproportionate to all other medical providers in the United States. In fact, the government's evidence shows that the defendant is the number one Medicare biller in the entire United States for certain incision-and-drainage and wound debridement surgical procedures identified in paragraph 8 of the Indictment in this case. The defendant frequently achieved this distinction by billing dramatically more procedures than the next highest provider who billed Medicare in the same period. The defendant claims that this evidence is irrelevant, because the defendant was not specifically aware of these statistics. (Def. Mot. at p. 5) The defendant's motion should be denied.

A. Relevant Facts

The government will offer testimony explaining that medical procedures performed by physicians are standardized across the United States and represented for billing purposes by five-digit codes known as Current Procedural Terminology ("CPT") codes. Physicians bill Medicare based upon a claim that medical procedures were performed as identified by the CPT codes. Medicare has a record of claims for payment by all physicians in the United States who submitted bills for each procedure.

As described in the Indictment in this case, from approximately January 1, 2011 through December 12, 2013, the defendant submitted numerous claims to Medicare for ten difference incision-and-drainage and wound debridement surgical procedures identified by the CPT codes set forth in paragraph 8 of the Indictment. During that time period, the defendant submitted claims for payment to Medicare totaling $85 million for those ten medical procedures and received approximately $7.3 million from Medicare in reimbursement. (Indictment at ¶ 2)

An analysis of Medicare claims data revealed that the defendant's billings frequently outpaced those of other providers who submitted claims for the same procedures. For example, as set forth in the government's letter dated January 22, 2016, the defendant received approximately $2 million in reimbursement from Medicare for claims for the procedure identified by CPT Code 22015 (Drainage of Abscess of Lower Spine or Sacrum). The claims data shows that the defendant billed a total of 3,577 of these procedures during the relevant time period. The next highest billing provider in the United States for this procedure received $21,000 in reimbursement for performing a total of 49 procedures during the same time period. In other words, the defendant billed Medicare for over 70 times the number of procedures as the next highest biller in the country for CPT Code 22015.

Similar discrepancies exist for almost all of the other CPT Codes identified in the indictment. For example, the defendant received approximately $981,000 in reimbursement from Medicare during the relevant period for performing approximately 2,143 procedures identified by CPT Code 27301 (Drainage of Abscess or Blood Collection at Thigh or Knee Region). The next highest biller for CPT Code 27301 in the country during that time received approximately $29,000 for performing 127 procedures. The defendant received approximately $918,000 in reimbursement from Medicare for performing approximately 1,077 procedures identified by CPT Code 27030 (Incision of Hip Joint with Drainage) during the time period identified in the indictment. The next highest biller in the country for CPT Code 27030 during the same time received approximately $14,000 for performing 67 of the procedures.

B. Discussion

Other Circuit courts have approved the use of such comparative evidence to support criminal convictions of physicians whose billing history was revealed to be less aberrational than the defendant's here. See United States v. Alexander, 748 F.2d 185, 188-89 (4th Cir. 1984) (peer group analyses presented into evidence by Blue Cross/Blue Shield and Medicaid investigator showed that the defendant ranked first or second compared to other area gynecologists regarding certain tests, which supported finding that tests were not performed); United States v. Russo, 480 F.2d 1228, 1234-36, 1243-44 (6th Cir. 1973) (peer group analyses presented into evidence by Blue Cross/Blue Shield demonstrated that the defendants, two osteopathic physicians, submitted approximately thirty-five percent of the claims paid for the five procedures at issue out of a total of 10,000 physicians practicing in the same geographical area; the court found this evidence relevant to the charges that "the defendants did not actually perform the extremely large numbers" of certain services for which they claimed reimbursement); United States v. Weinstock, 153 F3d 272, 278 (6th Cir. 1988) (peer group analyses based upon Blue Cross/Blue Shield claims data that compared a podiatrist's billings for arthrocentesis procedures to that of other podiatrist in the community provided context for the jury to evaluate the health care fraud-related charges against the defendant and was not overly prejudicial under Rule 403 in light of its relevance and the defendant's opportunity to argue to the jury about the weight that the evidence should be given).

Here, the evidence of the defendant's grossly disproportionate billings is directly relevant to proof that the defendant intended to defraud Medicare and that the defendant billed for procedures that he did not perform. Therefore, this evidence should be admitted as compelling circumstantial evidence of the crimes charged.

The defendant additionally opposes admission of evidence that the defendant's Medicare billing "radically increased beginning in January 1, 2011," which was at the beginning of the charged scheme to defraud. (Def. Mot. at p. 5). This evidence of his purposeful changed behavior will also prove the defendant's intent to defraud.

Moreover, the defendant is expected to argue that he is not guilty of executing a scheme to defraud, because he made mistakes when submitting his claims for reimbursement to Medicare. Evidence that the defendant's billing were so ridiculously disproportionate to that of all of the other medical providers contradicts the defendant's claim and proves absence of mistake.

Nor should the evidence be excluded because its probative value is substantially outweighed by the danger of unfair prejudice to the defendant under Rule 403. (Def. Mot. at p. 6) The claims data is determined by comparing the total number of claims paid for the procedures at issue submitted by all doctors to the total number of claims filed by the defendant. See Russo, 480 F.2d at 1236. These are the defendant's own statements to Medicare for payment. In essence, defendant's claims for payment constitute his own statements that he performed the services described in the billing.[3]

Moreover, the defendant himself created the damaging evidence by submitting the claims. Because the government has the burden of proof, it should be allowed to present this evidence, which is highly probative of an element of the government's case. Any resulting prejudice to the defendant flows directly from his false statements. The evidence clearly does not cause "unfair" prejudice to the defendant under a Rule 403 analysis.

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[3] These bills would be admissible under Rule 801 (d)(2)(A) as statements of the defendant.

IV. Identification of Claims Related to Operating Room Logs and Impossible Days

The government filed a letter on January 22, 2016, in an abundance of caution, to ensure that the defendant understood that documents, which had been previously provided to him at least five months ago, including Medicare claims and payment data, remittance advice statements and hospital operating room logs, would potentially be used, likely in the form of summary charts, to show: (1) that there was no record of the defendant using operating rooms at times when he submitted claims to Medicare that indicated that he had performed procedures there and (2) that the defendant's Medicare billings showed that the defendant billed for more surgical procedures on certain days than was realistically possible.

The defendant claims that the government should have provided notice through a Bill of Particulars of the specific claims underlying this potential evidence and asks the Court to order the government to immediately provide a list of the claims underlying the aforementioned analysis. We disagree that this information is the proper subject of a Bill of Particulars. Moreover, the requested information has been previously provided, albeit not in the format the defendant now requests. The government nonetheless agrees to provide the defendant with the list of the claims.

CONCLUSION

For the reasons set forth above, the government respectfully requests that the Court deny the defendant's motions in limine.

Dated: Brooklyn, New York
February 19, 2016

Respectfully submitted,

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